rates were 82 and 95% ($P < .05$). Results of AVS altered localization of disease compared with what had been anticipated based on preoperative imaging, and thus influenced surgical decision making in 23 (43%) of cases. There were no false positives based on surgical resection.

**Conclusions:** AVS is an important procedure in the work up of hyperaldosteronism to help identify and localize metabolically active tumors. It is an additional area in medicine where a vascular surgeon can lend expertise. Success with the procedure improves with experience and should be done by high volume surgeons.

**Author Disclosures: N. C. Clarke**: Nothing to disclose; **I. Epelboym**: Nothing to disclose; **H. L. Gill**: Nothing to disclose; **N. Kabutey**: Nothing to disclose; **I. Kim**: Nothing to disclose; **J. A. Lee**: Nothing to disclose; **N. J. Morrissey**: Nothing to disclose; **J. J. Siracuse**: Nothing to disclose.

## C6g: Poster Session-Peripheral Arterial Disease (1)

### PS110.

### Comparative Effect of Carvedilol Versus Bisoprolol in Patients Undergoing Femoropopliteal Stenting

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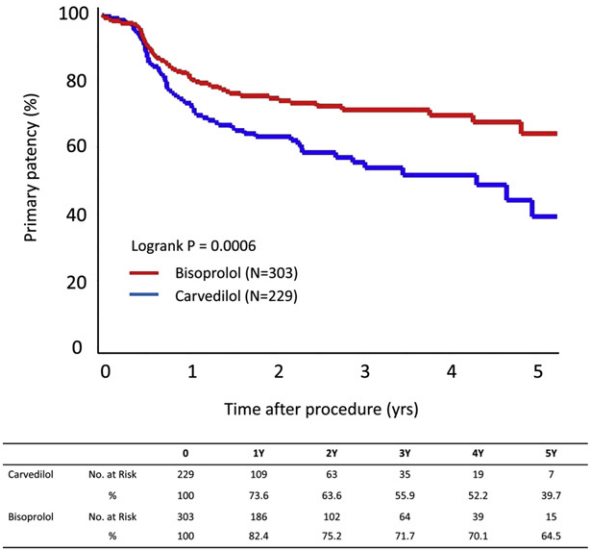
**Objectives:** To compared the effects of beta-blokers in patient undergoing femoropopliteal stenting.

**Methods:** This study was a multicenter retrospective registry of prospectively maintained database. Between January 2004 and December 2011, 438 patients (532 limbs) who treated by carvedilol (187 patients, 229 limbs) or bisoprolol (251 patients, 303 limbs) were identified and analyzed. The endpoints of this study were primary and secondary patency, overall survival and freedom from major adverse limb events (MALE; includes any repeat revascularization and major amputation). The mean follow-up period was 27+/−17 months.




| | | 0 | 1Y | 2Y | 3Y | 4Y | 5Y |
|---|---|---|---|---|---|---|---|
| Carvedilol | No. at Risk | 229 | 109 | 63 | 35 | 19 | 7 |
| | % | 100 | 73.6 | 63.6 | 55.9 | 52.2 | 39.7 |
| Bisoprolol | No. at Risk | 303 | 186 | 102 | 64 | 39 | 15 |
| | % | 100 | 82.4 | 75.2 | 71.7 | 70.1 | 64.5 |

**Fig.** Primary patency after femoropopliteal stenting in patients with bisoprolol and with carvedilol.

**Results:** Primary patency was significantly higher in the bisoprolol-treated group than in the carvedilol-treated group (71.7% vs 55.9% at 3-year; $P = .0006$). Secondary patency and freedom from MALE were also significantly higher in the bisoprolol-treated group (92.7% vs 76.1% at 3-year; $P = .0004$ and 75.2% vs 58.0% at 3-year; $P < .0001$, respectively). However, overall survival was similar between both groups (82.0% vs 82.6% at 3-year; $P = .44$). After correcting with baseline variables, bisoprolol was found to be effective for primary patency (Hazard ratio 0.56, 95% confidential interval 0.37 to 0.83, adjusted $P = .005$).

**Conclusions:** In the vessel patency and the incidence of MALE after femoropopliteal stenting, patients in whom bisoprolol was given experienced better than those in whom carvedilol was given.

**Author Disclosures: O. Iida**: Nothing to disclose; **Y. Soga**: Nothing to disclose.

### PS112.

### Comparison of Outcomes Between Bare Metal and Covered Nitinol Stents in the Treatment of TASC C and D Superficial Femoral Artery (SFA) and Popliteal Lesions

Jesus Matos[2], Carlos F. Bechara[1], Neal R. Barshes[1], Briauna Lowery[1], George Pisimisis[1], Sherene Sharath[1], Peter H. Lin[2], Panos Kougias[1]. [1]Surgery, Michael E. DeBakey VAMC, Houston, Tex; [2]Baylor College of Medicine, Houston, Tex

**Objectives:** We sought to determine the relative effectiveness of bare metal (BM) and covered stents (CS) when used in the treatment of patients with long TASC-II D SFA and popliteal lesions.

**Methods:** This was a retrospective cohort analysis of consecutive patients with SFA and popliteal TASC II type C and D lesions, who underwent endovascular intervention for claudication or critical limb ischemia with either BM or CS. Cox regression was used for time to event analysis and logistic regression for analysis of categorical outcomes. All results are reported adjusted for statistically significant covariates.

**Results:** We studied 166 patients for an average of 18 (range, 3-42) months. Treated lesions had an average length of 32 cm (range, 15-52 cm) and included total occlusions (n = 91) and mixed stenoses and occlusions (n = 75). Covered stents were more commonly placed for total occlusions (71% vs 44%; $P = .001$). The BM stents were more commonly placed in patients on statins (79% vs 60%; $P = .014$). Otherwise the two groups were similar in age, Rutherford stage on initial presentation, runoff status, and comorbidity distribution. The primary patency for the CS vs the BM group was 61% vs 43%, 42% vs 27%, and 34% vs 20% at 12, 18, and 24 months respectively ($P = .03$). Secondary patency for the CS vs the BM group was 76% vs 73%, 62% vs 65%, and 56% vs 65% at 12, 18, and 24 months respectively ($P = .65$). Major amputations (HR, 1.85; $P = .4$), open reinterventions (HR, 1.43; $P = .34$) and endovascular reinterventions (HR, 1.41; $P = .43$) were similar between the groups. Patients with claudication

as initial indication for treatment who received BM stent were less likely to develop critical limb ischemia after stent occlusion (OR, 0.25; $P = .016$).

**Conclusions:** Compared to BM stent use of CS in the treatment of advanced SFA and popliteal lesions is associated with higher primary patency rates. Patients are more likely to advance from claudication to critical limb ischemia after failure of a covered stent.

**Author Disclosures: N. R. Barshes**: Nothing to disclose; **C. F. Bechara**: Nothing to disclose; **P. Kougias**: Nothing to disclose; **P. H. Lin**: Nothing to disclose; **B. Lowery**: Nothing to disclose; **J. Matos**: Nothing to disclose; **G. Pisimisis**: Nothing to disclose; **S. Sharath**: Nothing to disclose.

## PS114.

### Gender Differences in the Long-Term Outcomes of Infrainguinal Arterial Revascularization: Retrospective Multicenter Analysis

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**Objectives:** The purpose of this study is to evaluate the gender differences in the long-term outcomes of infrainguinal revascularization, in multi-center experience.

**Methods:** This study was multicenter retrospective analysis from January 2004 to December 2009. 1001 limbs (696 men; group1 and 305 women; group2) underwent infrainguinal arterial revascularization; endovascular therapy and bypass surgery. Male and female group were compared in terms of primary patency and secondary patency. Patencies were assessed by either duplex ultrasound or angiography, analyzed by Kaplan-Meier estimation and compared by the log rank test.

**Results:** There were no differences in all cause death, MACE and MALE between two groups. At 6 years, the primary patency rate were 48.2% (male group) and 32.1% (female Group) ($P = .0001$), secondary patency rates were 80.5% and 68.9% ($P = .0008$).

Gender (HR, 1.40; 95% CI, 1.15 to 1.73; $P = .001$) and critical limb ischemia (HR, 1.61; 95% CI, 1.16 to 2.23) were risk factors of infrainguinal artery restenosis.

**Conclusions:** Significant sex differences exist with regard to the outcomes in infrainguinal arterial revascularization.

**Author Disclosures: K. Ichihashi**: Nothing to disclose; **Y. Soga**: Nothing to disclose.

## PS116.

### Smoking Cessation and Clinical Outcomes in Young Patients Undergoing Endovascular Treatment for Critical Limb Ischemia

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**Objectives:** Endovascular treatment is being offered more and more to young patients with critical limb ischemia (CLI), but patency rates and outcomes have been reported as modest. This study assesses outcomes of endovascular revascularization in young CLI patients according to their smoking attitude.

**Methods:** Outcomes after endovascular treatment performed from 2005 to 2012 were retrospectively revised in patients aged <50 years at the time of revascularization. Risk of reintervention and limb loss were assessed according to timing of smoking cessation, adjusted for clinical confounders.

**Results:** Percutaneous angioplasty was performed on 112 limbs of 86 patients with CLI (Rutherford category 4 = 19.7%; 5 = 70.5%; or 6 = 9.8%). Initial technical

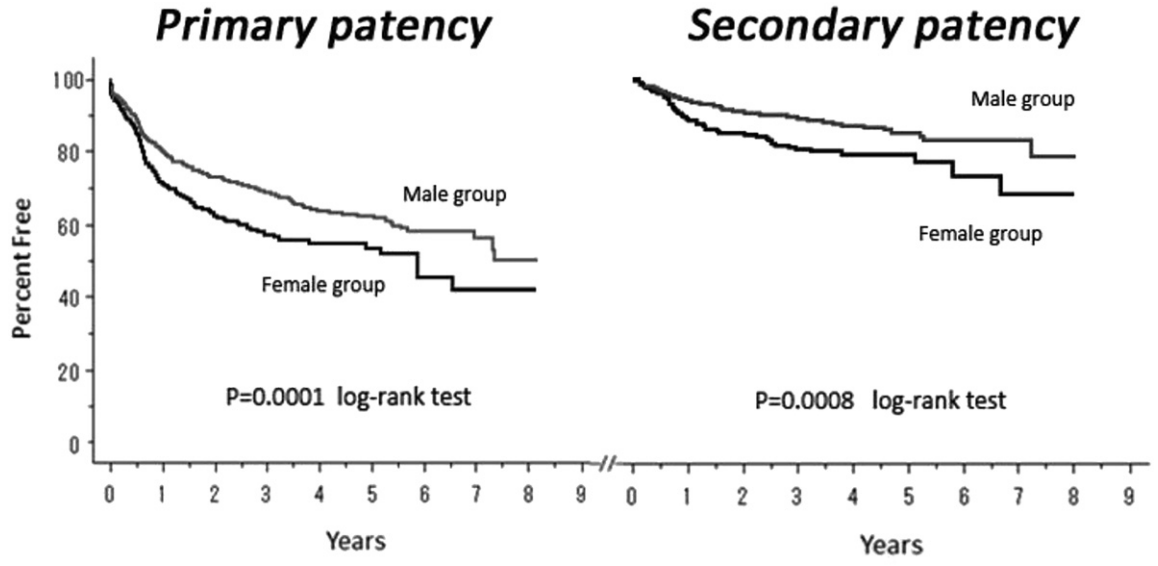


**Fig.**